The Division of Medicaid (DOM) and/or the Centers for Medicare and Medicaid Services (CMS) may terminate any Medicaid participating nursing facility's provider agreement if a nursing facility:

- Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present, **or**
- Fails to submit an acceptable plan of correction within the timeframe specified by CMS and/or the Division of Medicaid, **or**
- Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS and/or the Division of Medicaid (DOM), **or**
- Does not meet the eligibility criteria for continuation of payment as set forth in 42CFR 488.412(a)(1) and 42CFR 448.456, i.e., CMS or DOM may terminate the nursing facility's provider agreement or may allow the facility to continue to participate for no longer than six (6) months from the last day of the survey if the facility has not met all requirements under this section.

## Notice of Termination

Before terminating a provider agreement, CMS and/or DOM must provide written notification to the facility and public notification via local and/or general newspaper publication as follows:

- At least two (2) calendar days before the effective date of the termination for a facility with immediate jeopardy deficiencies, **and**
- At least fifteen (15) calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.

## Reimbursement

When a provider agreement is terminated, federal regulations provide that payments may continue for no more than thirty (30) days from the date the provider agreement is terminated if it is determined that:

- Reasonable efforts are being made to transfer the residents to another facility, community care, or other alternate care, **and**
- Additional time is needed to effect an orderly transfer of the residents.

## Discharge and Relocation of Residents

Within forty-eight (48) hours of receipt of the termination notice, the facility must send written notification to each Medicaid resident, legal representative and/or responsible party, and attending physician, advising them of the action in process. In addition, the facility must submit the following to DOM and to the State Survey Agency, Mississippi State Department of Health, Division of Health Facilities Licensure and Certification: (1) a current list of Medicaid residents, (2) the name, address and telephone number

(when available) of the legal representative and/or responsible party, and (3) the name of the resident's attending physician. The census, including transfer and discharge information, must be updated daily and faxed to DOM.

Medicaid staff will also notify the resident, legal representative and/or responsible party. Medicaid staff can assist both the resident and the facility in making arrangements for relocation to another facility. The resident or the resident's legal representative and/or responsible party must be given opportunity to designate a preference for a specific facility or for other alternative arrangements. A resident's rights/freedom of choice in selecting a facility or alternative to nursing facility placement must be respected. A facility chosen for the relocation of a Medicaid beneficiary must be: (1) Title XIX certified and in good standing under its provider agreement, and (2) able to meet the needs of the resident.

A new Pre-Admission Screening (PAS) application is not required for DOM beneficiaries transferred to a new facility. The discharging facility must submit a DOM-317 indicating a transfer to another facility. Include the name and address of the new facility on the 317 form.

When a resident is transferred, **all** of the following reports, records, and supplies must be transmitted to the receiving facility:

- A copy of the current physician's orders for medication, treatment, diet, and special services required.
- Personal information such as: (1) name and address of next of kin, legal representative, or party responsible for the resident, (2) attending physician, (3) Medicare and Medicaid identification number, (4) social security number, and (5) other identification information as deemed necessary and available.
- All medication dispensed in the name of the resident for which a physician's orders are current. The medications must be inventoried and transferred with the resident. Medications past the expiration date and/or discontinued by physician order must be inventoried for disposition in accordance with state law.
- The residents' personal belongings, clothing, and toilet articles. An inventory of personal property and valuables must be made by the closing facility.
- Resident trust fund accounts maintained by the closing facility.

## Resident Trust Fund Accounts

Resident trust fund accounts maintained by the closing facility must be properly inventoried and receipts obtained for audit purposes by DOM. All documentation needed to perform an audit of the residents' trust fund account must be maintained and available for review. This includes, but is not limited to, residents' trial balances, residents' transactions histories, bank statements, vouchers, receipts of purchases, etc. In addition, the facility must maintain a current surety bond to cover the total amount of funds in the trust fund account.

## Reinstatement After Termination

When a provider agreement has been terminated by the Office of Inspector General (OIG), CMS and/or Medicaid under 42CFR 489.53, a new agreement with that provider will not be accepted unless it is found that:

- The reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur, **and**

- The provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

To be considered for re-instatement in the Medicaid program, DOM must receive: (1) a notification of re-instatement from the appropriate entity, and (2) an application for re-instatement to participate in the Medicaid program. The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date.